October 23, 2017

Jeri Herrera, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

Dear Ms. Herrera:

On October 13, 2017, a survey was conducted at Valley Vista Care Center Of Sandpoint by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.
After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by November 2, 2017. Failure to submit an acceptable PoC by November 2, 2017, may result in the imposition of penalties by November 17, 2017.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by November 17, 2017 (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on January 11, 2018. A change in the seriousness of the deficiencies on November 27, 2017, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by January 11, 2018 includes the following:

Denial of payment for new admissions effective January 11, 2018. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on April 11, 2018, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on January 11, 2018 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process  
  2001-10 IDR Request Form

This request must be received by **November 2, 2017**. If your request for informal dispute resolution is received after **November 2, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

![Signature]

David Scott, RN, Supervisor  
Long Term Care

DS/lj  
Enclosures
The following deficiencies were cited during the federal recertification survey conducted at the facility from October 10, 2017 to October 13, 2017.

The surveyors conducting the survey were:

Edith Cecil, RN, Team Coordinator
Shane Reed, RD
Susan Devereaux, RN

Abbreviations:
ADON = Assistant Director of Nursing Services
BID = Twice daily
BIMS = Brief Interview for Mental Status
CDC = Center for Disease Control
CNA = Certified Nursing Assistant
CVA = Cerebrovascular Accident (stroke)
DNS = Director of Nursing Services
HS = Hour of sleep
LPN = Licensed Practical Nurse
LTC = Long-term care
mg = Milligram
MDS = Minimum Data Set
RN = Registered Nurse
RAI = Resident Assessment Instrument
SCOC = Significant Change of Condition

(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a “significant change” means a major decline or improvement in the
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 274</td>
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<td>resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on record review and interview, it was determined the facility failed to complete assessments when residents experienced significant changes in their health and functional status. This was true for 2 of 15 residents (#2 and #5) reviewed for assessments and had the potential for harm if resident cares were planned without adequate knowledge of their current health status and needs. Findings include:</td>
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<td>1. Resident #2 was admitted to the facility on 6/7/17 with diagnoses that included end stage/terminal prostate cancer.</td>
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<td>The admission Minimum Data Set (MDS) assessment, dated 6/13/17, and the quarterly MDS assessment, dated 9/11/17, documented Resident #2's health and functional status had declined. Specifically, the MDS assessments documented:</td>
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<td>* 6/13/17 Admission MDS - Intact cognition</td>
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<td>* 9/11/17 Quarterly MDS - Moderately impaired cognition</td>
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<td>* 6/13/17 Admission MDS - Supervision and set-up assistance only required with eating</td>
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<td>* 9/11/17 Quarterly MDS - Extensive assistance of 1 staff required with eating</td>
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<td>This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in</td>
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F 274 Continued From page 2

* 6/13/17 Admission MDS - Supervision and set-up assistance only required with personal hygiene
* 9/11/17 Quarterly MDS - Extensive assistance of 1 staff required with personal hygiene

* 6/13/17 Admission MDS - "Frequently incontinent" of bladder, "always continent" of bowel
* 9/11/17 Quarterly MDS - "Always incontinent" of bladder, "frequently incontinent" of bowel

* 6/13/17 Admission MDS - No significant weight loss
* 9/11/17 Quarterly MDS - Unplanned, significant weight loss

On 10/11/17 at 10:50 am, the MDS Coordinator stated Resident #2 had experienced multiple changes in his health and functional status and the facility should have completed a Significant Change MDS rather than a quarterly MDS. The MDS Coordinator said it was the facility's policy to complete a Significant Change MDS within 14 days of determining the resident's changes were permanent rather than temporary. The MDS Coordinator stated Resident #2's alterations in health and functional status were permanent and not a condition of his terminal illness, therefore, the facility should have completed a Significant Change MDS assessment on 9/11/17 rather than a quarterly MDS.

The facility's MDS Completion and Submission Timeframes policy, dated October 2013, documented, "Our facility will conduct and submit resident assessments in accordance with current compliance with requirements of participation or that corrective action was necessary.

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Resident Specific:
Resident number #2's current clinical condition was evaluated on 10/31/2017 and a SCOS assessment was scheduled for 11/6/2017. Resident #5's current clinical condition was evaluated on 10/31/2017. His condition was found to have returned to his baseline and his care plan was appropriate to meet his current needs. His condition will continue to be monitored and assessments scheduled accordingly.

Other residents:
All residents experiencing clinical declines in condition are at risk for the deficient practice of failure to perform a SCOS assessment. During the week beginning 10/30/2017 and ending 11/3/2017, an audit was conducted of all current residents' clinical conditions with comparison made between their current status and their previously assessed status. Residents found with indicators of possible or confirmed need for SCOS assessments were scheduled for such.

Facility systems:
The MDS nurses both received education regarding the qualifying criteria for a SCOS assessment and the facility's Policy and Procedure related to the same
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<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>Federal and state submission timeframes. Significant Change in Status Assessment ... will be completed on the &quot;14th calendar day after determination of significant change in status.&quot;</td>
<td>Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency</td>
</tr>
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</table>

2. Resident #5 was admitted to the facility on 1/12/16 with diagnoses that included dementia with behavioral disturbances, Type II diabetes mellitus, and depression.

Four (MDS) assessments completed between 1/16/17 and 7/4/17 documented Resident #5's health and functional status had declined. The MDS assessments documented:

* 1/16/17 Annual MDS
  - Minimal depression
  - Independent with bed mobility, transfers, and ambulation in his/her room
  - Supervision only required for locomotion on-and off unit as well as in the corridor
  - Set-up and supervision only required for dressing, toileting, eating, and personal hygiene
  - "Always continent" of bowel and bladder.

* 3/21/17 Quarterly MDS
  - Mild depression
  - Limited assistance of 1 staff required for bed mobility, locomotion in room, as well as on- and off unit
  - Limited assistance of 2 staff required for ambulation in the corridor
  - Extensive assistance of 2 staff required for transfers
  - Extensive assistance of 1 staff required for dressing, eating, toileting, and personal hygiene
  - "Occasionally incontinent" of bowel and bladder.

on 10/30/2017. Beginning at the facility's next scheduled Resident at Risk (RAR) meeting, currently scheduled on 11/7/2017, all residents experiencing changes in clinical condition, as identified via the twenty four hour report, will be discussed by the IDT and the MDS nurse. Clinical records will be reviewed and the decision will be made to either proceed with scheduling a SCOS assessment or the resident will be placed on monitored status for a period of time not to exceed 14 days to determine if the clinical change will be self-limiting. Residents on monitored status will be discussed by the IDT at each weekly RAR until the final determination is made to either initiate a SCOS assessment or end the monitoring. These discussions and observations will be documented in the resident's clinical record.

Monitoring:
Beginning the week of 11/05/2017. The Corporate Compliance Nurse or designee will audit the findings of the RAR meeting and the MDS nurse's decision regarding the need for either a SCOS assessment or further monitoring to ensure appropriate plans of action have been initiated. These audits will continue weekly for four weeks, biweekly for two months, and then monthly for two months. The findings of these audits will be discussed at the monthly QAPI meeting. At the end of five months of monitoring, the QAPI committee will determine the need for and frequency of ongoing monitoring.
### SUMMARY STATEMENT OF DEFICIENCIES

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<th>ID</th>
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* 6/19/17 Quarterly MDS  
  - Moderate depression  
  - Independent with bed mobility  
  - Extensive assistance of 1 staff required for transfers  
  - Limited assistance of 1 staff required for walking in the room, corridor, on- and off-unit, and personal hygiene  
  - Extensive assistance of 1 staff required for transfers, dressing, eating, toileting,  
  - "Frequently incontinent" of bladder,  
  "occasionally incontinent" of bowel

* 7/4/17 Quarterly MDS  
  - Moderate depression  
  - Limited assistance of 1 staff required for bed mobility, walking in room, as well as on- and off-unit  
  - Extensive assistance of 1 staff required for transfers, dressing, eating, and personal hygiene  
  - Extensive assistance of 2 staff required for toileting  
  - "Frequently incontinent" of bowel and bladder

On 10/11/17 at 12:35 pm, when asked if there was a significant change of condition assessment (SCOC) completed for Resident #5 due to the multiple changes in his/her status, the MDS Coordinator stated the SCOC was not completed as medication adjustments were occurring. The MDS Coordinator provided a stack of pink post-it notes that documented:

* January - Zyprexa 2.5 mg (milligrams) HS, (bedtime,) Celexa 30 mg daily, Depakote 125 mg BID, (twice daily) Melatonin 3 mg HS, and
<table>
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>F 274</td>
<td>Continued From page 5</td>
<td>Trazadone 50 mg at HS.</td>
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<td>* February - Zyprexa 5 mg HS, Depakote 125 mg BID, Celexa 30 mg daily, Melatonin 3 mg HS, and Trazadone 50 mg at HS.</td>
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<td>* March - Celexa 30 mg daily, Zyprexa 2.5 mg BID, Depakote 125 mg BID, Melatonin 3 mg HS, and Trazadone 50 mg at HS.</td>
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<td>* April - Lamictal 25 mg HS, Celexa 30 mg daily, Depakote 125 mg BID, Zyprexa 2.5 mg BID, Melatonin 3 mg HS, and Trazadone 50 mg at HS.</td>
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<td>The MDS Coordinator stated she did not document an explanation in the resident's clinical record for not completing the SCOC assessment.</td>
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<td>F 323</td>
<td>SS=D</td>
<td>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>F 323</td>
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<td>(d) Accidents. The facility must ensure that -</td>
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<td>(1) The resident environment remains as free from accident hazards as is possible; and</td>
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<td>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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<td>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</td>
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<td>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</td>
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### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

135055

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING ____________________________

B. WING ____________________________

**(X3) DATE SURVEY COMPLETED**

10/13/2017

---

**NAME OF PROVIDER OR SUPPLIER**

VALLEY VISTA CARE CENTER OF SANDPOINT

**STREET ADDRESS, CITY, STATE, ZIP CODE**

220 SOUTH DIVISION SANDPOINT, ID 83864

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARIZED STATEMENT OF DEFICIENCIES</th>
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(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed’s dimensions are appropriate for the resident’s size and weight. This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined the facility failed to ensure oxygen cylinders were stored and handled in a safe manner. This had the potential for harm should a cylinder become damaged and endanger residents. Findings include:

On 10/12/17 at 1:20 pm, CNA #2 was observed outside the laundry room placing tags on oxygen cylinder tanks. CNA #2 removed 9 tanks from an approved storage bin and placed them on the sidewalk.

CNA #2 stated it was “easier this way,” and noted she had bumped her knuckles placing tags on the tanks while they were in the storage bin. The Maintenance Supervisor, who was present during the observation, stated, “[I’ve] never seen that before.”

A compressed oxygen safety data sheet provided by the facility directed staff to "protect cylinders from physical damage; do not drag, roll, slide or drop."

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

| ID PREFIX | TAG | F323
|-----------|-----|-----|
|           |     | Resident Specific:
|           |     | This identified deficient practice did not affect any residents as it occurred outside of the building and no residents were present. The risk related to improper handling of oxygen cylinders placed CNA #2 and other staff present in the area at risk of injury should the cylinders fall to the ground. This was rectified immediately upon identification of the deficient practice as CNA #2 promptly secured the cylinders per policy.

Other residents:

Any resident in an area with improperly stored or handled oxygen would be at risk if this deficient practice were to be repeated. A facility wide audit of oxygen storage and handling was conducted by the NHA on 10/31/2017 to ensure all oxygen cylinders are stored and handled appropriately. No issues were identified.

**Facility systems:**

CNA #2 received education on the importance of proper handling and storage of oxygen cylinders by the NHA on 10/16/2017. An in-service regarding
**NAME OF PROVIDER OR SUPPLIER**

VALLEY VISTA CARE CENTER OF SANDPOINT

**STREET ADDRESS, CITY, STATE, ZIP CODE**

220 SOUTH DIVISION

SANDPOINT, ID  83864

**SUMMARY STATEMENT OF DEFICIENCIES**

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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**F 323** 11/9/17

483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

1. In excessive dose (including duplicate drug therapy); or
2. For excessive duration; or
3. Without adequate monitoring; or

proper handling and storage of oxygen cylinders will be provided to all staff responsible for such beginning 10/30/2017 and will be ongoing. Additionally, signage was placed on the oxygen storage bin outlining proper storage and handling procedures on 10/31/2017.

Monitoring:
Beginning the week of 11/05/2017. The NHA or designee will perform random audits of staff handling and storage of oxygen cylinders to ensure compliance is maintained. These audits will continue weekly for four weeks, biweekly for two months, and then monthly for two months. The findings of these audits will be discussed at the monthly QAPI meeting. At the end of five months of monitoring, the QAPI committee will determine the need for and frequency of ongoing auditing.
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<th>ID PREFIX TAG</th>
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| F 329         | Continued From page 8  
(4) Without adequate indications for its use; or  
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.  
483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--  
(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  
(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, it was determined the facility failed to ensure residents received psychotropic medications only when clinically indicated for the treatment of specific conditions. This was true for 1 of 4 residents (#9) reviewed for psychotropic medication use and had the potential for harm should residents receive psychoactive medications that were unwarranted, ineffective, or used for excessive duration without benefit to the resident. Findings include:  
| F 329         |                                                                                                                                  |               |                                                                                                                 |                |
| F329          | Resident Specific:  
Resident #9 was evaluated by the facility’s consulting psychiatrist on 10/16/2017. His recommendations for medication changes were forwarded to resident #9’s attending physician and guardian for consideration. His medication regimen was adjusted to include use of Zyprexa to alleviate |               |                                                                                                                 |                |
Resident #9 was admitted to the facility on 4/17/17 with multiple diagnoses, including traumatic brain injury, cardiovascular accident (CVA - stroke), epilepsy, anxiety disorder, dementia with behavioral disturbances, and major depression.

A Psychotropic Medication Consent Form completed for Clonazepam, dated 2/3/14, documented the medication was ordered to treat Resident #9's dementia and combative behaviors.

Physician Orders, dated 9/4/15, documented Resident #9 was to receive Clonazepam, 1 milligram (mg) three times daily for dementia with combative behaviors.

The 2018 Nursing Drug Handbook documented Clonazepam is an anticonvulsant. Potential adverse side effects included aggressive behaviors, agitation, hostility, anxiety, and irritability.

A gradual dose reduction (GDR) request to Resident #9's physician from the facility's Interdisciplinary Team (IDT), dated 1/10/17, documented, "[Resident #9] continues to exhibit combative behaviors with all aspects of care, aggressive with left hand and arm, arches back moves over and around in bed or chair with any stimulation. Please review and advise."

The physician responded on 1/10/17 by checking a box next to the pre-filled statement, "The patient has had good response to treatment and requires this dose for condition stability. Dose distressful combativeness on 10/22/2017. His condition will be monitored weekly at the behavioral team meeting and further needs discussed promptly with his MD.

Other residents:
The Behavior Care Director and Behavior Care Program Assistant received education on the regulatory requirement at F329 on 10/31/17. All residents receiving anxiolytic therapy to help combativeness related to dementia are at risk for this deficient practice. An audit of all residents receiving anxiety medication for combativeness related to dementia was conducted by the facility's Behavioral Care Program RN on 10/31/2017 and will be completed by 11/3/2017. Any resident found to be appropriate for consideration of medication therapy changes will be discussed with their PCP by 11/3/2017.

Facility systems:
Beginning 11/6/2017, all residents receiving anxiolytic therapy for combativeness due to dementia will be discussed at the weekly behavioral team review meeting. Residents found to have no positive change in their symptoms after three months of medication therapy will be presented to the facility's consulting psychiatrist for evaluation of medication therapy changes. Additionally, each resident's use of anxiolytics will be reviewed monthly by the facility's consulting pharmacist. Any recommendations will be promptly
F 329 Continued From page 10

reduction is contraindicated because benefits outweigh risks for this patient and a reduction is likely to impair the resident's function and/or cause psychiatric instability."

An IDT Progress Note, dated 7/28/17, documented Resident #9 swung his left arm and broke the glass to a framed picture hanging nearby during an activity. The resident’s clinical record documented he/she pulled his/her feeding tube from its insertion site on 8/12/17.

A quarterly Minimum Data Set (MDS) assessment, dated 8/28/17, documented Resident #9 was rarely/never understood, did not speak, experienced severe cognitive impairment, never/rarely made decisions, had little interest or pleasure in activities, was short-tempered and annoyed, exhibited physical behaviors toward others (hitting, kicking, pushing, scratching, and/or grabbing) and rejected cares daily.

A Behavior Care Plan, updated 9/12/17, documented Resident #9’s behaviors were related to traumatic brain injury (TBI), dementia, expressive aphasia, and CVA. Target behaviors included being combative with activities of daily living, yelling out, hitting/slapping at staff, and smearing feces.

Behavior Monitors documented the following:

Combative with cares:

* 9/2016 = 72 episodes
* 1/2017 = 69 episodes
* 3/2017 = 91 episodes
* 6/2017 = 80 episodes
* 8/2017 = 59 episodes
Physical aggression not related to cares:
* 9/2016 = 40 episodes
* 1/2017 = 24 episodes
* 3/2017 = 0 episodes
* 6/2017 = 50 episodes
* 8/2017 = 16 episodes

Smearing feces:
* 9/2016 = 3 episodes
* 1/2017 = 12 episodes
* 3/2017 = 4 episodes
* 6/2017 = 3 episodes
* 8/2017 = 1 episode

A Medication Regimen Review provided no new suggestions for managing Resident #9's medications or behaviors exhibited since September 2016.

The facility's Medication Utilization and Prescribing-Clinical Protocol, revised September 2012, documented staff and physicians were to identify and address unexpected, unintended, undesirable, or excessive responses to a medication. Staff and physicians were also directed to identify and address any adverse drug reactions and worsening medical conditions.

On 10/11/17 at 2:30 pm, RN #4, who also served as the facility's Behavioral Care Program Director, stated, "We don't attempt dose reductions if the [doctor] does not order it." RN #4 stated Resident #9 was "on a trayful of medications when he was admitted and we got rid of them." When RN#4 was asked if she thought the Clonazepam was helping Resident #9, she stated, "I don't think it is anymore."
### Summary Statement of Deficiencies

**F 441 SS=D 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS**

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

2. Written standards, policies, and procedures for the program, which must include, but are not limited to:

   (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

   (ii) When and to whom possible incidents of communicable disease or infections should be reported;

   (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

   (iv) When and how isolation should be used for a resident; including but not limited to:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

135055

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED

10/13/2017

NAME OF PROVIDER OR SUPPLIER

VALLEY VISTA CARE CENTER OF SANDPOINT

STREET ADDRESS, CITY, STATE, ZIP CODE

220 SOUTH DIVISION
SANDPOINT, ID 83864

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 441
Continued From page 13
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to ensure universal infection control precautions were practiced during the provision of wound care and administration of medications. This was true for 2 of 16 residents (#15 and #16) reviewed for infection control practices and had the potential for harm if staff failure to observe standard infection control practices led to the

F 441
Resident Specific:
There is no additional action to take for resident #s 15 or 16 as the deficient practice by the nursing staff occurred and was brought to the attention of the staff afterward.
Other residents:
All residents receiving wound care by
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

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| F 441 | Continued From page 14 | Spread of contagious organisms. Findings include:  
1. Resident #15 was admitted to the facility on 9/1/17 with diagnoses that included Type II diabetes mellitus, peripheral nervous system disorders, chronic obstructive pulmonary disease, hemiplegia, cognitive communication deficit, and pressure ulcers.  
On 10/13/17 at 8:48 am, Licensed Practical Nurse (LPN) #2 was observed providing wound care to Resident #15’s 3 open wounds; a macerated area; and 2 new wounds that opened from a purple area first discovered on the coccyx area upon return from a hospital emergency room. LPN #2 opened a pack of two sterile cotton tipped applicators, pulled one out and threw away the pack with the remaining applicator still in the packaging. LPN #2 then dipped the applicator into a pre-poured cup containing MediHoney (medical-grade honey products for the management of wounds and burns) and applied it to three different wounds by dipping the used applicator back into the MediHoney after application was completed for the first and second wound.  
The facility’s Administering Topical Medications policy, revised October 2010, documented: “Apply [medicated] Paste, cream, ointment or lotion … Remove tongue blade or alternate applicator from wrapper … Place medication on the tongue blade or applicator … Repeat as necessary to cover the entire area, using a new tongue blade for each application.”  
On 10/13/17 at 11:05 am, the Director of Nursing |
| F 441 | | | LPN# 2, nebulizer administration by the ADON or LPN #1, or ADL assistance by CNA #1 are at risk related to this deficient practice. Each of these staff members received one on one education regarding the deficient practice on 10/30/2017. Facility systems: Facility systems by way of policies and procedures are already in place directing staff in proper infection control techniques. Beginning 10/26/2017 and ongoing, all direct care staff will be reeducated on these policies and procedures and the expectation of policy and procedure adherence.  
Auditing: Beginning the week of 11/5/2017, the DNS or designee will begin randomly auditing staff during the provision of cares to ensure that hand hygiene is appropriately completed. Additionally she or her designee will audit wound care weekly to ensure proper infection control techniques are used. These audits will continue weekly for four weeks, biweekly for two months, then monthly for two months. Finding of the audits will be shared monthly with the QAPI committee. At the end of five months of auditing, the QAPI committee will determine the need and frequency of ongoing monitoring. |
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| F 441 | Continued From page 15 | Services (DNS) stated that per the facility's Administering Topical Medications policy, a new applicator should have been used when providing treatment for each of Resident #15's wounds. On 10/13/17 at 11:43 am, LPN #2 stated she should have used a new applicator for each wound. 2. After assisting with Resident #15's positioning during wound care on 10/13/17, Certified Nurse Assistant (CNA) #1 entered the resident's bathroom at 8:56 am to perform hand hygiene. CNA #1 turned the water on then turned the water off 6 seconds later, dried her hands with a paper towel, and exited Resident #15's room. Immediately after CNA #1 left Resident #15's room, the bathroom sink was observed with a single blade style handle, rather than foot pedals, for turning on- and off the water. On 10/13/17 at 11:47 am, CNA #1 stated she used her hand to turn off the water, but knew she should have used a paper towel to dry her hands and turn off the water. CNA #1 stated she did not realize the length of time it took her to wash her hands was inadequate per universal precaution standards. 3. On 10/13/17 at 8:22 am, LPN #1 was observed entering Resident #16's bathroom, where she washed her hands for 6 seconds. After setting up a nebulizer treatment for Resident #16, LPN #1 returned to the bathroom and performed hand hygiene that included washing her hands for 4 seconds. At 8:26 am,
### Valley Vista Care Center of Sandpoint

#### Street Address, City, State, Zip Code
220 South Division
Sandpoint, ID 83864

#### Statement of Deficiencies and Plan of Correction

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The Assistant Director of Nursing (ADON) entered the resident's room to assist with the treatment, washed her hands for 11 seconds and helped reposition Resident #16. The ADON then returned to the resident's bathroom, where she washed her hands for 6 seconds. After the completion of the treatment, LPN #1 performed hand hygiene in the resident's bathroom that lasted 11 seconds from the time the water was turned on to the time LPN #1 pulled the paper towel to dry her hands.

The facility's Handwashing/Hand Hygiene policy, revised August 2015, documented: "Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) ... at a comfortable temperature. Hot water is unnecessarily rough on hands. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. Discard towels into trash."

On 10/13/17 at 10:45 am, the ADON stated she had sung "Happy Birthday" to herself while washing her hands and thought that was long enough.

On 10/13/17 at 11:42 am, LPN #1 stated hand washing should include a 20 second scrub time.

The Centers for Disease Control (https://www.cdc.gov/handhygiene/providers/index.html) documented, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product..."
### Statement of Deficiencies and Plan of Correction

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<th>(X2) Multiple Construction</th>
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<td>B. Wing _____________________________</td>
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**Name of Provider or Supplier:**

VALENCY VISTA CARE CENTER OF SANDPOINT

**Street Address, City, State, Zip Code:**

220 SOUTH DIVISION
SANDPOINT, ID 83864

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**Summary Statement of Deficiencies**

*(Each deficiency must be preceded by full regulatory or LSC identifying information)*

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**F 441**

Continued From page 17

Recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."

**F 463**

483.90(g)(2) Resident Call System - Rooms/Toilet/Bath

(g) Resident Call System

The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.

(2) Toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility did not ensure its emergency call system was accessible to residents and/or staff. This was true for 1 of 5 bathing rooms (200 hall shower room) and had the potential to adversely affect 14 residents on the 200 hallway who bathed in the shower room. Findings include:

On 10/12/17 at 1:30 pm, the shower room on the 200 hall was observed with a shower stall on the right side of the room and a toilet to the left side of the room with a wall dividing the room. The room is

**Resident Specific:**

Upon identification of the need for relocation of the call lights on 10/12/2017, the shower room identified was placed out of operation. No additional resident-specific action needed taken. Other residents:

No residents are at risk for this deficient area. The shower room identified as needing call light system alterations was placed out of operation until the call lights were relocated on 10/16/2017.

**F463**

Resident Specific:

Upon identification of the need for relocation of the call lights on 10/12/2017, the shower room identified was placed out of operation. No additional resident-specific action needed taken. Other residents:

No residents are at risk for this deficient area. The shower room identified as needing call light system alterations was placed out of operation until the call lights were relocated on 10/16/2017.
### Facility Systems

**Emergency Call Light Placement**

- **F 463**
  - Continued From page 18
  - Emergency call light was located on the inside wall to the left of the entry door approximately 8 to 10 feet from the door to the toilet and approximately 8 feet from the door to the center of the shower stall. The emergency light was functioning, however, a resident utilizing the toilet or shower independently would be unable to access the call light in case of an emergency.

  - The maintenance supervisor stated an emergency call light would be placed near the toilet and shower.

- **F 463**
  - Facility systems:
    - The call lights in the identified shower were relocated on 10/16/2017 to be within reach of any resident utilizing the toilet or shower. No additional changes necessary.
    - Auditing:
      - As these call lights are permanently affixed in their proper locations, there is no further auditing needed.
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<td>C 000</td>
<td>16.03.02</td>
<td>INITIAL COMMENTS</td>
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<td>The following deficiencies were cited during the facility's state licensure survey from 10/10/17 to 10/13/17.</td>
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<td>The team members conducting the survey were:</td>
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<td></td>
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<td>Edith Cecil, RN, Team Coordinator</td>
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<tr>
<td>C 409</td>
<td>02.120,05,i</td>
<td>Required Room Closet Space</td>
<td>C 409</td>
<td></td>
<td></td>
<td>11/9/17</td>
<td>Facility requests continuation of waiver.</td>
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<td>i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20&quot; x 22&quot;) per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on resident and staff interview, and plan review, it was determined the facility failed to ensure the required 3 square feet per resident of personal closet space was provided for residents in rooms in the 100 and 300 halls. The small closets created the potential for residents to have insufficient space for storing clothing and personal items. Findings include: Closets in the 100 hall provide 2.43 square feet (36 inches x 19.5 inches) and 2.41 square feet (33 inches by 21 inches) per resident in the 300 hall.</td>
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On 10/11/17 at 10:30 am, residents residing in rooms 108 and 304 without roommates stated they had no complaints regarding their closet space.

On 10/11/17 at 1:00 pm, the DON requested continuation of a waiver for the less than required closet space.

C 422 02.120,05,p,vii Capacity Requirements for Toilets/Bath Areas

vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.

This Rule is not met as evidenced by:

Based on interview and a waiver in effect, it was determined the facility failed to ensure there was 1 tub or shower for every 12 licensed beds. The failure had the potential for a negative effect for all residents living in the facility. Findings include:

The facility, licensed for 73 beds, was required to have 7 tubs or showers available for resident use. The facility had 5 bathing facilities.

On 10/11/17 at 11:00 am, a Group Interview was conducted with 9 residents who denied concerns or issues about insufficient bathing facilities.
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<tr>
<td>C 422</td>
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<td>C 422</td>
<td>On 10/11/17, the DON requested a continuation of the waiver for the required number of tubs or showers.</td>
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<tr>
<td>C 664</td>
<td>02.150,02,a Required Members of Committee</td>
<td>C 664</td>
<td>11/9/17</td>
<td>C 664</td>
<td>Corrective action: On 10/31/2017, the IDT was educated on the state requirements for required members of the Infection Control Committee.</td>
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<td>Other residents: All residents have the potential to be affected by this deficient practice.</td>
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<td>Facility Systems: The IDT and Infection Control Committee have been educated to the committee requirements for the state of Idaho. All required members of the committee will be present no less than quarterly per the state requirements. The Infection Control Committee attendance log has been updated to better identify each member of the committee and their title.</td>
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<td>Monitoring: Beginning at the next scheduled Infection Control meeting in the month of November, the administrator or her</td>
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On 10/13/17 at 11:45 am, the Administrator provided staff attendance records for the Infection Control Committee meetings. She reported that Infection Control is combined with the Quality Assurance meetings, which meet monthly.

Attendance records provided by the facility documented a pharmacy representative did not attend the Infection Control meeting held October through December 2016 and January through March 2017.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** MDS001540

**Date Survey Completed:** 10/13/2017

**Name of Provider or Supplier:** Valley Vista Care Center of Sandpoint

**Street Address, City, State, Zip Code:** 220 South Division, Sandpoint, ID 83864

### Summary Statement of Deficiencies

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<th>ID</th>
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<td>C 664</td>
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The designee will schedule the Infection Control Committee meetings so that all members are able to attend. The administrator or designee will monitor and report any deficient findings to the Safety Committee and a make-up meeting will be scheduled promptly to maintain compliance.